

**PHOENIX AREA INDIAN HEALTH SERVICE  
AREA INTERVENTION TEAM INTAKE FORM**

1. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Referring Counselor: \_\_\_\_\_
2. Referring Agency: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_
3. Agency's Fax number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ E-mail (if applicable): \_\_\_\_\_
4. Client's Name: \_\_\_\_\_ Gender: M ☐ F ☐ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_
5. S.S.N.: \_\_\_\_-\_\_\_\_-\_\_\_\_ Client's Address: \_\_\_\_\_  
City, State Zip Code
6. Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Tribal Affiliation: \_\_\_\_\_
7. Parent/Guardian/Extended Family/Legal Guardian Name: \_\_\_\_\_
8. Parent/Guardian's S.S.N.: \_\_\_\_-\_\_\_\_-\_\_\_\_ For Women with dependent children accompanying client (please list dependent children's Name, Social Security Number, Date of Birth, and Address): \_\_\_\_\_  
\_\_\_\_\_
9. Reason for referral: \_\_\_\_\_
10. Testing (e.g., SASSI: Substance Abuse Subtle Screening Inventory, SUDDS: Substance Use Diagnostic Disorders Schedule, MAPP: Multidimensional Addiction & Personality Profile: ASI: Addiction Severity Index, DAPA: The Drug and Alcohol Problem Screen) completed: ☐Y ☐N Provide Results (Numerical and interpretation): \_\_\_\_\_  
\_\_\_\_\_
11. Issues associated with Substance Abuse: \_\_\_\_\_  
\_\_\_\_\_
12. Current Physical Examination (Required within 30 days) ☐Y ☐N Medical Problems (if any): \_\_\_\_\_  
\_\_\_\_\_
13. Psychological/Psychiatric evaluation on record? ☐Y ☐N If yes, please submit a copy of the report with this intake form. (Consisting of: 1. Mental Status, 2. Current and past abnormality, 3. Family history of psych. Problems, 4. Motor functioning, 5. Cognitive functioning with emphasis any learning impairment that might influence diagnosis & treatment, 6. Panic Attacks, delusions, or any thought disorder, 7. Degree of danger to self or others).
14. Diagnostic Impressions: Axis-I \_\_\_\_\_
15. List ASAM Dimensions # met and a statement to justify residential placement: \_\_\_\_\_  
\_\_\_\_\_

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16. Depression: No History ☐ Mild ☐ Moderate ☐ Severe ☐  
17. Past suicide history: ☐Y ☐N Currently Suicide Risk: ☐Y ☐N  
18. Anger/Violence: ☐Y ☐N History of Using Weapons: ☐Y ☐N Explain: \_\_\_\_\_  
19. **PAST TREATMENT HISTORY:** In-patient/Residential: ☐Y ☐N if yes, where? \_\_\_\_\_

Type of Discharge? \_\_\_\_\_ When? \_\_\_\_\_

Outpatient: ☐Y ☐N if yes how long? \_\_\_\_\_

20. Grief issues/Loss of close personal relationship: \_\_\_\_\_

21. Family Involvement: \_\_\_\_\_

22. Family care plan completed? ☐Y ☐N (please submit a copy to the Area office A/SAP)

23. Continuing care responsibilities (who will be the clients primary support network; i.e., parents, grand-Parents, foster parents. After treatment, whom will s/he be staying with after treatment)? \_\_\_\_\_

24. **LEGAL ISSUE:** Current Charges: ☐Y ☐N In detention: ☐Y ☐N On Supervised Probation: ☐Y ☐N  
Court-ordered for Treatment: ☐Y ☐N if yes, consequence for non-compliance? \_\_\_\_\_

Any special provisions (Wheelchair, other limitations requiring assistance, Client might be in handcuffs)? \_\_\_\_\_

[Please inform the Travel Coordinator for the Phoenix Area A/SAP]

25. Medicaid/AHCCCS enrolled: ☐Y ☐N CHS Eligibility: ☐Y ☐N Private Insurance: ☐Y ☐N Parent Financial Responsibility Form: ☐Y ☐N If court referred or ward of court, will the court pay for Treatment *travel* expenses if referred to private facility? ☐Y ☐N Will court pay for *treatment* services? ☐Y ☐N

\* The Phoenix Area Intervention Team (A.I.T.) requires (5) business days to review and complete the placement process. Court ordered for treatment is not considered as justification for residential placement.

\* [Please note that once the ticket has been issued for the client-escort, it cannot be changed. The escorting person must plan accordingly].

\* All communication with A.I.T. must be coordinated through the local program counselor.

Revised 03/2001